THIS MUST BE COMPLETED AND MAILED WITH EMPLOYEE'S FIRST REPORT OF INJURY
SUPPLEMENT TO IA-1
EMPLOYER'S FIRST REPORT OF INJURY

VOLUNTEER AMBULANCE SERVICE

1. Name of Volunteer Ambulance Service _____

   Address _____

   Contact Person _____ Phone Number _____

2. Was ambulance personnel working in capacity of Volunteer at time of accident? _____

3. Does ambulance personnel receive any pay other than per run pay? _____ If yes, how much? _____

4. Does ambulance service carry any other policies? _____

   Workers' Compensation _____ Disability _____

   If so, name of company _____ Policy benefit _____

VOLUNTEER AMBULANCE PERSONNEL

1. Name of Volunteer Ambulance Personnel _____

   Address _____

   Telephone _____

2. Name of Volunteer's Regular Employer (Not Ambulance Service)

   Nature of Business _____

3. Volunteer's Occupation (Not Ambulance Service) _____

4. Name of Supervisor _____ Phone Number _____

5. Number of Hours Worked Per Day _____ Per Week _____

6. Number of Days Worked Per Week _____

7. Wages: _____ Per Hour _____ or Per Day _____ or Per Week ___

8. If paid on other than a time basis (piece rate, salary, commission, etc.) enter actual average weekly earnings:
   $ _____ per week.

Workers' Compensation
Personnel Cabinet
Room 511, 200 Fair Oaks Lane
Frankfort, Kentucky 40601
(502) 564-6846

PLEASE COMPLETE ALL QUESTIONS ON THIS FORM!